

Consent for use in School Internship Sites

ART THERAPY CONSENT TO ASSESSMENT, INDIVIDUAL, AND/OR GROUP SERVICES

Art Therapy is a mental health service offered to your child for short term support based on the nature of the partnership with EVMS and the structure of the internship. Art Therapy in the school is aimed to increase social and emotional skills for academic and personal success. Art Therapy in the school setting may assist students in working through social, emotional, or behavioral challenges that impact educational success. Art Therapy may also support positive character development through psycho-educational and art-based experiences. The art therapist and child will develop goals for working in art therapy. The art therapist may consult with the educational team to provide helpful strategies and seek additional information to assist the child.

_____ **IF** your child receives mental health services, counseling, or psychiatric medications, please *(Initials)* consult with the primary provider before consenting for your child to participate in art therapy. In addition, it is best practice for providers, including Art Therapy and Counseling Interns, to have written consent to collaborate with primary providers to insure ethical best practices and the welfare of your child's mental health care. There may be risks of multiple providers working with individuals, particularly if there is not coordination of care and treatment planning.

I consent for my child _____ to participate in:
(print child's name)

☐ Art Therapy: Assessment, Individual, and/or Group Art Therapy

_____ I understand that all services provided by an Art Therapy and Counseling Intern (student in training) are *(Initials)* supervised by EVMS Graduate Art Therapy Program Faculty and information is disclosed in supervision to enhance planning and client safety. Any information about you, your child, and your child's artwork is held with utmost confidentiality and can only be released by either your written signed consent or by court order. I understand that information that helps my child succeed in the academic environment will be shared with the education team.

1. When I sign a form authorizing release of my child's records;
2. My child acknowledges intent to harm him/herself or others;
suspicion or disclosure of abuse of a child or adult;
are subpoenaed.
3. When there is a
4. When my child's records

USING CLIENT ARTWORK

I, _____, agree to allow this Art Therapy and Counseling Intern to use and/or display and/or photograph my
Parent/guardian name child's artwork
for the following purpose(s):

- Educational purposes through graduate art therapy program at Eastern Virginia Medical School
- Consultation with other mental health professionals (includes supervision)
- Presentation at professional conferences

- Publication in a professional journal
- Exhibition

Conditions: _____

CONFIDENTIALITY WILL BE MAINTAINED

This Art Therapy and Counseling Intern agrees to the following conditions in connection with my use of artwork by _____:
Client

I agree to safeguard your artwork to the best of my ability and to notify you immediately of any loss or damage while your art is in my possession.

I agree to provide an appropriate format for presentation, if I exhibit your artwork, and to bear other costs related to the exhibition.

I agree to return your artwork immediately if you decide to withdraw your consent.

I agree to safeguard your confidentiality.

Print Name: _____ Signed: _____ Date: _____
Art Therapy and Counseling Intern

My signature below provides consent for art therapy by the EVMS Art Therapy and Counseling Intern as noted in the descriptions above.

Print Name: _____ Signed: _____ Date: _____
Student/Client

Print Name: _____ Signed: _____ Date: _____
Legal guardian

Consent revoked by: _____ Date: _____